Baby's Name *(Last, First)* or Imprint:

New Jersey Department of Health and Senior Services
Early Hearing Detection and Intervention Program
PO Box 364
Trenton, NJ 08625-0364

NEWBORN HEARING FOLLOW-UP REPORT

Date of Birth	Sex	Medical Record No.

Also Known As	Primary Language	EBC No.

Name of Parent/Guardian (Last, First)	Relationship to Child	Mother's Maiden Name (if different)

Street Address	Telephone No.

City	State	Zip Code	Mother's Insurance No.

Name of Baby's Primary Care Provider	Telephone No.

Address	Reason for Testing
	☐ Not Screened in Hospital ☐ Failed Previous Screen ☐ Risk Factor Code (see back): _____
Facility of Birth	☐ Other: _____

OUTPATIENT *SCREENING* RESULTS

Screening Type	**Outpatient** Screen Date
☐ Initial Screening ☐ Repeat Screening	☐ Missed Appt.

Method:	Tympanometry Done
☐ TEOAE ☐ DPOAE ☐ ABR ☐ Both	☐ Yes ☐ No
Results: Right Left	Tested at: _____ Hz
☐ ☐ Pass at 30 dB	Results:
☐ ☐ Fail	Right Ear: ☐ Normal ☐ Abnormal
☐ ☐ Not Tested	Left Ear: ☐ Normal ☐ Abnormal

DIAGNOSTIC AUDIOLOGIC EVALUATION

Evaluation Type	Date of Evaluation
☐ Initial ☐ Periodic Follow-up	

Evaluation Method(s)

- ☐ Diagnostic ABR
  - ☐ Click Evoked Only or ☐ Frequency Specific
  - ☐ Air Conduction or ☐ Bone Conduction
- ☐ ASSR
- ☐ BOA
- ☐ COR
- ☐ VRA
- ☐ Play Audiometry
- ☐ Soundfield Audiometry
- ☐ Tympanometry

Results:

Right	Left	
☐	☐	Normal Hearing **OR**
		Type of Loss:
☐	☐	Conductive (possibly transient)
☐	☐	Permanent Conductive (atresia, anotia, etc.)
☐	☐	Sensorineural
☐	☐	Mixed
☐	☐	Other (specify): _____

Degree of Loss (Pure Tone Average):
Right Ear: _____ dB loss Left Ear: _____ dB loss

RECOMMENDATIONS

- ☐ Passed, No Further Testing Needed Unless Clinically Indicated
- ☐ Passed / Re-screen for Late Onset Loss at (Age): _____
- ☐ Auditory Habilitative Management
- ☐ Referred to (Name/Phone No.): _____
  For: _____

Name and Title of Evaluator	Telephone Number

Agency Name and Address

CHILD WITH HEARING LOSS MUST BE REGISTERED WITH SCHS REGISTRY

I have registered the Child: ☐ YES on Date: _____

SCH-2
JAN 03

Distribution: Original - NJDHSS Copy - Primary Care Provider Copy - Evaluator File

INSTRUCTIONS FOR COMPLETING THE NEWBORN HEARING FOLLOW-UP REPORT (SCH-2)

This form should be completed by the person completing outpatient newborn hearing testing on all infants who either:

1) were not tested during their birth hospitalization and are receiving initial screening as an outpatient OR
2) failed inpatient screening and are being re-evaluated OR
3) passed prior hearing evaluations, but are at increased risk for hearing loss and are receiving periodic follow-up testing

Demographic Information: As an alternative to completing all demographic fields (name, address, etc.), you may use an addressograph, sticker, or attach a copy of an outpatient registration form that contains the relevant information. Please be sure attachments are securely connected to the Follow-up Report and that all fields are completed on either the form or the supplemental documentation.

Also Known As: Please indicate if the baby may be known under any additional names.

EBC No.: If known, please enter the unique identification number created by the EBC system when the birth certificate record is generated, to assist in matching the child for identification of risk factors for hearing loss.

Risk Factor: If testing is being done due to a risk factor for hearing loss, indicate code from the following list:

- AP Apgar score 0-4 at 1 minute or 0-6 at 5 minutes
- CO Parental/caregiver concern about hearing or speech
- CR Craniofacial anomalies exclusive of isolated skin tags including, but not limited to, abnormalities of the pinna and ear canal, low hairline, cleft palate
- EC ECMO (Extra Corporeal Membrane Oxygenation)
- HX Family history of hereditary childhood sensorineural hearing loss
- HY Hyperbilirubinemia requiring exchange transfusion
- MN Meningitis (bacterial or viral)
- NI NICU admission of >= 2 days
- OM Recurrent or persistent otitis media with effusion (OME) for at least 3 months
- OT Ototoxic drugs given to baby, including, but not limited to, the aminoglycosides, used in multiple courses or in combination with loop diuretics, for example, gentamicin, kanamycin, furosemide
- PH Persistent pulmonary hypertension
- ST Stigmata or other findings associated with a syndrome known to include a sensorineural and/or conductive hearing loss, including, but not limited to, Waardenberg, Klippel-Feil, Down
- TO In utero infection (TORCH)
- TR Head trauma
- VE Prolonged mechanical ventilation five days or longer
- VL Very low birth weight (<1500 grams)

Screening Results: This section is for detailing outpatient *initial screening* or *re-screening.* Please indicate pass/fail separately for each ear.

Diagnostic Testing Results: This section is for detailing outpatient *diagnostic testing results.* Please indicate pass/fail separately for each ear.

Note that all children with ANY non-transient hearing loss (including unilateral loss) must be registered with the Special Child Health Services registry. To obtain registration forms, please contact the SCHS Registry Program at 609-292-5676.

Recommendations: This section should be completed on ALL forms.

Abbreviations:

- TEOAE – transient evoked otoacoustic emissions
- DPOAE – distortion product otoacoustic emissions
- ABR – auditory brainstem response
- ASSR – auditory steady state response
- BOA – behavioral observation audiometry
- COR – conditioned orienting reflex audiometry
- BRA – behavioral response audiometry
- VRA – visual response audiometry

Completed forms should be sent to:

New Jersey Department of Health and Senior Services
Special Child, Adult and Early Intervention Services
Newborn Hearing Program
PO Box 364
Trenton, NJ 08625-0364

To request additional forms, or for questions, please contact the Early Hearing Detection and Intervention Program at 609-292-5676